

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 11, 2003
10:20 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Workplan for assessing the quality of care in Medicare

-- Karen Milgate

MR. HACKBARTH: Next up is our work plan for assessing quality of care. Karen.

MS. MILGATE: Before I get started, I just want to acknowledge that the work plan you're about to hear about is the result of my work, but also there's two colleagues that I worked very closely with. That is Sharon Cheng and Anne Marshall. And you'll be seeing more of them at this podium as we go along this fall.

What I'm about to present is a work plan for primarily the product would be a chapter in the March report, whose purpose would be to give a broad overview of quality of care in the Medicare program.

But you'll see as I go along that we hope our efforts to pull together a robust set of indicators to look broadly at Medicare will also support our other quality work.

Our work is being done in the context of a variety of other efforts, private and public, to measure and improve quality. The IOM, as you are all probably aware, issued a report several years ago which really outlined the problem and the scope of the problem particularly in the area of patient safety. And then a couple of years later issued a report, the Quality Chasm Report, that outlined a vision for how to improve quality as well as a framework for how to get there.

We've talked in these meetings before also about the efforts of the large purchaser group called the Leapfrog Group to really push the envelope in terms of quality and particularly safety in some of their identification of very specific leaps, as they call them, in the quality improvement.

In addition, we've also talked in these meetings about the various efforts that CMS is undertaking. They worked with the QIO program to develop measures, to measure quality, and actually work with providers to improve. They have their public reporting initiative which has really engendered a lot of discussion in the settings of nursing homes and home health, as to how to improve quality.

And then they also have their pay for performance demonstrations, which are sort of in line with the recommendations the Commission made in the June report, for how to actually put together payment incentives for improving quality. And there are many other insurer and purchaser efforts.

All of the efforts that I have just outlined, including MedPAC's work, require data on quality. Several sets of indicators are now available that could provide a broad overview of the quality of care for Medicare beneficiaries. In addition, we think they could support some of our other MedPAC work on quality. Here, I just want to outline the various efforts on our agenda that we think that this work could help.

First of all, in terms of overall monitoring, the goal here

is to create as robust a set of quality data as possible to be able to look at quality from a variety of different perspectives. So we're trying to do that and there's obviously a lot of other people trying to create that robust set for their own purposes.

We also think in this area it will be interesting to see how the different indicators sets do or don't move in the same direction. You may see one aspect of quality where it looks different than another aspect of quality, in terms of either trends or in different regions. Or in fact, if we find that they all seem to be moving in the same direction, that's a pretty good indicator that we really are seeing something about the quality of care either nationally or in that particular region.

In addition, for purposes of payment adequacy, we are intending on looking at national trends in certain settings to see if quality has remained the same, improved, gotten worse over time. As well, as we hope to be able to compare urban/rural areas, particularly potentially for settings where there are differences in payment based on urban and rural distinctions.

For our future work on incentives, we're hoping that looking at these various indicator sets will help us target those incentives. It could possibly help us identify some of the largest gaps in quality, particular types of conditions or particular procedures, or particularly settings that are more problematic than others.

In addition, to help us get a better handle of what kinds of measures are out there and where measures may be best in particular settings. That could help us either in our work, but also in recommendations to Congress or CMS on where they may target future efforts in this area.

While most of the data we'll be looking at this year we don't intend on looking at at the provider-specific level, i.e. a particular hospital or a particular physician, we're hoping by getting more familiar with these various indicator sets, we may be able to identify some that would be useful at the provider-specific level to help us to begin to examine the relationship between cost and quality in particular settings.

So on the last slide what I was hoping to do is give you a sense of how we might use the information that comes out of the data we hope to obtain. This one and the next one I just want to describe the indicators and give you a sense of what they would tell us about quality more specifically.

These various sets of indicators that you see listed in this chart represent over several hundred indicators of quality which are some in specific settings, some give you a broad program overview, and some are on specific aspects of quality.

To organize our thinking, and as you've seen it on the slide, what we did was organize these in terms of the four domains of quality that IOM identified. Those would be the clinical effectiveness, patient safety, patient-centeredness and timeliness. You can see from the slide that clearly there are more data in clinical effectiveness. You can also see that some of the information we get, for example, for clinical effectiveness is also information that can be used for looking at timeliness of care. So some of these indicator sets give us

information in different domains of quality.

You can also see, looking just briefly at the timeliness domain, that the information within a domain can be quite different. For example, the CAHPS for fee-for-service and Medicare+Choice is a beneficiary survey, so it's a beneficiary perception of the timeliness of the care they're getting overall and in some specific settings.

However, the ACE-PRO ambulatory care measures really look at are beneficiaries getting clinically necessary services in the ambulatory setting? And some of those are based on timing. Are diabetics being seen twice a year? Are those discharged after a certain procedure in a hospital getting a follow-up visit within four weeks? So there are different aspects of quality even within each domain.

There's also one relationship I'd like to point out that I think is an interesting one in the clinical effectiveness domain. We have two indicator sets there that look specifically at ambulatory care, and one looks at the process of ambulatory care. That would be the ACE-PROs. Did beneficiaries receive clinically necessary services in the ambulatory settings? And it kind of counts whether they got the services or not.

And then the AHRQ prevention quality indicators really look at the outcomes of that care. Those really measure whether beneficiaries were admitted to a hospital for conditions that if they had gotten those appropriate clinically necessary services they may not have needed that hospital admission.

So we may see some interesting interrelationships between indicator sets as well.

The last slide I just wanted to go somewhat briefly over the primary indicator sets we are planning on running. The first is a set of patient safety indicators which looks at adverse events in hospitals. These were developed by AHRQ through a contract with UCSF-Stanford and their evidence-based practice center. There are 16 Medicare relevant indicators that we hope to look at. The beauty of these indicators are they run off of administrative data. So that gives us a lot of ability to look at these from a variety of different angles.

The second set I've listed there is mortality by condition and procedures. And again, that's in hospitals. These were also developed by AHRQ with a contract with UCSF-Stanford. There are six condition-specific ones and eight procedure ones. They basically look at 30-day mortality for these variety of conditions and procedures. Again, they run off of administrative data.

The next two look at care in ambulatory settings. One is the indicators that we've used before here, primarily to look at access. That would be the Access to Care for the Elderly Project, the ACE-PRO measures, which also have implications for quality. So we will tend to use them in both the access world, as we monitor access, as well as looking at quality of care in the ambulatory care setting.

And they look at, as I described briefly earlier, whether beneficiaries are actually getting clinically necessary services in the ambulatory setting. So they identify, for example,

diabetics in the Medicare program and look at the types of clinically necessary services they are obtaining.

The next one is the AHRQ set of indicators, as again as I mentioned on the other slide which were also developed by AHRQ. These they call the prevention quality indicators and they measure the percentage of beneficiaries -- is it in a hospital or in an area? But the number of beneficiaries who are admitted to the hospital for conditions that if they had obtained appropriate ambulatory care they may not have needed that hospital visit. For example, amputation for a diabetic is one of those ambulatory care sensitive conditions.

The CAHPS for fee-for-service and M+C, again is a beneficiary survey. It's administered by CMS. That gives us information on how beneficiaries perceive the communication skills overall of providers as well as specific providers. It asks them questions about whether they were actually able to obtain care when they needed it, and provides information both generally but also to specific settings. So we're hoping that will give us some sense of the beneficiary perception of quality of care, both nationally and then also in specific regions.

In addition to this work, and I also should draw a line here, there is all the other work that goes on through the setting-specific work on payment adequacy that other analysts are doing in their own specific settings to really get some sense of how quality may have changed over time, both in SNFs, for example, Susanne hopes to look at readmissions for particular conditions. Dialysis, we are pretty used to being able to look at quality trends in dialysis. As well in home health, we're hoping to be able to look at some outcomes in home health area.

DR. MILLER: Can I say one thing? This is really minor but I just don't want you to get the sense that this is a disconnected process. In fact, all of the quality work is now -- we have a group of people who come together, work with Karen, and all the quality has its own agenda plus it travels out into the payment adequacy area. That's a very conscious change in how we're doing things.

I just didn't want you to get the sense that this was going on in a silo basis.

MS. MILGATE: I have an other there just simply to note there is a couple of other datasets that are different than these in the sense that we can really only get national data and we intend on looking at, for example, what the QIO program has found over time, as well as the RAND indicators. There was an article in the New England Journal a few months ago. They have indicated to us that it's possible to run those just on Medicare, even though they did an overall look for that particular article. So we're hoping to be able to look at that, as well.

So that concludes my formal presentation. I'm interested in your thoughts on the breadth and scope of what we're proposing here, and any areas you want more work on, or questions.

DR. WAKEFIELD: It's actually one comment and two questions. The comment is more to Mark's last point and that was it was pretty obvious, in flipping through some of the chapters of the prep material that we received, that quality was being teased out

and run thematically through some of those sections. I just have to say thanks so much. I think that's just such a critically important focus. So I saw that connection. As a matter of fact, when I was going through, I was underlining it every time I saw it. So it's just a really nice reflection of the work that MedPAC staff are now doing and the directions that I think you're taking some of this beyond -- linking it to payment adequacy and then moving beyond just payment and access issues in trying to incorporate more of a focus on quality.

Two questions. One, have you had a chance to take a look at all or work with AHRQ's folks as they've been preparing their annual report on quality that's being vetted right now?

MS. MILGATE: Yes, actually I've talked with them a couple of different times about what measures they're going to be using and whether they're going to have Medicare-specific information. I haven't recently though, but yes, I've been in touch with them and I'm planning to have a conference call with Daniel Strier, and he was going to talk to me more specifics as they have gone along.

DR. WAKEFIELD: It just strikes me that as you're trying to key this up and lay out something of a framework, obviously there's going to be a lot of overlap in terms of how you're constructing the framework for this chapter. But it may well be informed by all the work they've put into constructing their report to Congress that I think is going to be released this fall.

So I just wanted to make sure that if it could help jump start even further some of the efforts that you're involved with right now, in terms of the framing of this, that might be really good resource given the intense effort that they've been engaged in their. --

MS. MILGATE: One of the results of our conversations actually is using the IOM framework. They're going one level of detail below what we did, which I don't think is really necessary for what we're our doing. But that is actually one thing that will be similar.

I also have talked to them about making sure that what we're doing is a little unique, so that in fact they're not running all the same thing and getting Medicare numbers. And they have generally told me that they're relying more on breakdowns. They're looking nationally clearly across all payers, but also they're focusing more on certain types of conditions and looking more specifically at conditions.

So I think that the two will actually relate very nicely, theirs coming out then and then this chapter in March.

DR. WAKEFIELD: And then my last question, I see you're using under clinical effectiveness SNF readmissions. Are you looking at all at using MDS-based nursing home quality measures that QIOs are already collecting, and that are being reported out on Nursing Home Compare? Are you going to use that as a source, at all, Karen?

MS. MILGATE: The issue that we've had with those, and we have thought about that, is that there are very few that are really specific to SNF, and they weren't really designed to

capture some of the types of quality issues you might have in SNFs.

The other issue is that the MDS is collected at a point in time, first of all, when beneficiaries will come into SNFs. But then often beneficiaries are released before there's a second one. So you don't get what you'd like to get, which is a change over time in the quality of what the beneficiary is experiencing.

So in our opinion, and this is something we continue to work on, as to how to maybe use that information better in the SNF realm, that you're really capturing more of a description of the patients in the SNF than actually the quality of care. How many have UTIs? How many have pain?

We have tended to feel that the readmission might give us a better picture of quality. I don't know if either of the SNF people would like to add anything to that, Susanne?

DR. SEAGRAVE: In my presentation later on this afternoon, I was going to just best briefly touch on that one of the things that we were planning to try to look at is exactly what you're talking about, and to see if we can identify any changes over time, just nationally in some of the short stay measures on the MDS publicly reported quality measures.

But Karen was very articulate in pointing out all of the problems and the caveats with that. That is part of our agenda, is the first answer to your question.

The other answer to your question is, as you know, those are also changing right now and so we're not sure what those are going to look like in the future. Those could potentially become more useful to us in the future.

DR. WAKEFIELD: I assume you're not collecting them broadly on all nursing home admissions because of the extent to which Medicare is or isn't a payer in that environment? Would that be true?

So I mentioned it in relationship to SNF, that you're choosing to use readmission data there, but in terms of trying to pull broader data on nursing homes, would that be the reason why you wouldn't go there and collect information on nursing -- like use MDS information that the QIOs are using more broadly, not just on SNF but on nursing home admissions across the board?

So what would the reason be why you wouldn't be using that broader set of data?

DR. SEAGRAVE: I think it's not accurate to say we're not using that broader set of data. We actually have that broader set of data and we're looking at it to the extent possible. The problem is that we want to make sure that the quality measures that we use are specific to short stay SNF patients versus the long stay residents, basically nursing home residents.

And that's a difficult process. We also don't have any research at this point on how closely the long stay measures correlate with the quality of the short stay residents. So we're working out all of those kinds of issues.

MS. DePARLE: Like Mary, I'm very excited about this agenda and thank you for the work you've done. I think even just laying out all the different data sources that we now have is very instructive. And it does appear we have some rich sources of

data now to mine.

I'd be interested in your comments on given our emphasis on data and current data, where you think we're lacking right now? Or if the staff has some views of that. Where do we still need more data?

And also how current is the data that we have? I know the QIO data is fairly current, and of course that's on a state-by-state basis. But what about the other sources? Is it going to be 2003 report on the experience in 1999? How current are we?

MS. MILGATE: The answer to the currency question is that several of these are run off of administrative data, so we can get pretty current data. It's probably a little bit different for each dataset. But I don't think any of them will go further than 2001, for example.

MS. DePARLE: [off microphone] So they're not linked--

MS. MILGATE: Right. In terms of your other question, I guess that would be something I would -- I mean, I could say something about, but I'm not sure if I shouldn't think a little bit before. Where are the gaps? I don't know if I want to -- you can see from the chart we put there, that clearly there are some gaps in -- I guess I would say one gap would be patient-centeredness. As you probably know, there are many different efforts to get, for example, of hospital-type CAHPS, a nursing home CAHPS. And there are plans under way to develop those. I think those will be very useful when you get to the specific setting.

But there's other clinical effectiveness types of measures that I think could be useful, too.

MS. DePARLE: What I remember, and this is dated a couple of years, that we didn't have much on fee-for-service and we're moving forward on that. It seems like we have a little more. But physician position office visits, for example, and that sort of physician office setting, was fairly bereft of data. And I don't know whether there's been progress made there or not.

MS. MILGATE: Certainly, as we talked about for the preparation for the June report, there is some progress there in terms of the concept of looking at particular conditions and what's happening at particular physician office.

I think the other issue for us specifically is that those data are not broken down by, for example, ambulatory surgery centers or outpatient. So we have this number for ambulatory care. But we don't know where the care is delivered.

So if you want to talk gaps, I've been frustrated, for example, looking at where can we get data on ASCs and outpatient. Those are big growing areas. They're doing technically sensitive work that could create some quality problems. And yet we don't have measures, let alone data.

And when you talk to people about ambulatory measures, they usually focus on the physician office. So that's a bit of a gap, I believe, particularly for us and CMS.

MS. DePARLE: I would just urge that we spend some time thinking about where the gaps are. I think that's been an important contribution that we've made in our data analysis so far.

DR. MILLER: I think that's completely fair. And Karen, if you said this then I apologize.

The other way you're thinking about your work is as people are focusing on physician and hospitals, the issue there is what data, how deep is it, how useful is it?

Whereas, in some other areas, and Karen thinks about this way, in some other areas that data is deep and the question now is how to use it to begin to incent providers. And I think hospitals and physicians are specifically two areas where you're going to be laying out for people what is known about those datasets.

MS. MILGATE: [off microphone] Definitely those would be the two areas where I would say -- there's others too, but hospitals and physicians do need a lot of work.

MS. DePARLE: Just one more point. I would also be interested in your comments, if any. There was a New England Journal of Medicine article about quality of care in the VA system versus Medicare that came out a few months ago. And other commissioners might be interested in it as well. Medicare did not compare as favorably as -- and I would be interested in your comments on that.

MS. MILGATE: Okay.

MR. HACKBARTH: Karen, when we look at datasets, some of these big datasets, one story is what's happening on average to the quality of care delivered to Medicare beneficiaries in a particular setting along particular dimensions. Another story is variability across institutions and to what extent the range is growing or narrowing or whatever.

Do we have the ability to talk about both stories or is it just going to be more the former?

MS. MILGATE: You'll need to explain to me a little bit more. Do you mean the range between different types of hospitals?

MR. HACKBARTH: Yes.

MS. DePARLE: For individual hospitals.

MS. MILGATE: The two large datasets, the indicator sets we have here, the patient safety indicators and the mortality conditions, we are I think through this process going to get a better sense of some of the sample size issues. For example, in the patient safety indicators, you're talking about fairly rare events. So you need pretty significant numbers to build those up.

So whether we would be able to go below like a certain fairly large region and have significant numbers would be a question.

The other issue with both of those is because they rely on administrative data you end up having coding issues, with different hospitals or different types of hospitals potentially coding differently. So for example, a comment I received from AHRQ when I was talking to them about using the patient safety indicators for looking at different types of hospitals was be very cautious about looking at academic versus non, because there may be some coding differences. There may be some coding practice differences between urban and rural.

I guess I wouldn't make any blanket statement now. What we're hoping to do this year is look at a fairly high level, I guess the lowest comparison level we're thinking of going to would be the breakdown of urban and rural areas that we did in our 2001 rural report. And then use the processing to get more information for our own heads about how we might use this in the future to look at different types of hospitals, for example. Does that answer your question?

MR. HACKBARTH: Ideally, it would be down to very small levels. But even if we're talking larger units, aggregations, geographic units, there are multiple stories here. One is the average, another is the distribution, the range across the country. To the extent possible, I think we need to be sensitive to both.

MS. MILGATE: So you're also saying just a range, not just getting down to different types but how much variation is there within a measure?

MR. HACKBARTH: Yes.

MS. MILGATE: I think we should be able to do that, yes.

MR. MULLER: I, too, commend you and the staff for taking this on. I think providing a road map in the whole quality arena is of critical importance, given how much people have been discussing it over the course of last 10 years. But there are still, as you know, so many different ways of approaching it. And I think the lack of a standard way of talking about quality makes it more difficult for there to be the kind of aggressive measures to improve it, because people look at it in such different ways.

So I have two hypotheses that I want to offer to you. One is that trying to have more standard ways of talking about it, I think, is going to be imperative towards the improvement of quality in health care. I think right now, with such an enormous variety of ways in which people approach it, people will take different tacts, which I think reflects the kind of diversity of health care in America but also makes it more difficult to have a broad movement to improve across certain broad metrics. So that's one of my hypotheses, is until we get more standard ways of talking about, it is going to be more difficult to improve it.

My second hypothesis is that we also need to ultimately understand this at the provider level, at the disease level, and at the population level. And until we have that, it also becomes difficult to take the kind of steps because there is, just consist with the dialogue that Glenn just had with you, I suspect there's such variation going on -- just like there is in financial performance -- that one really does have to understand it at those very different levels.

The provider level, I think, is very obvious. I think the disease level is also somewhat apparent, because how somebody may treat heart disease at an institutional level is quite different than how they may treat neurological diseases, cancer, et cetera, and so forth.

Third obviously, is the populations that are being served vary so much in their underlying condition that therefore the kind of interventions one makes, either medically or surgically,

et cetera, vary quite a bit based on the underlying condition of the population. This does complicate matters.

So one of the things that I will be asking you to be thinking about is until we are ultimately able to put the information together at that level that understands at least those three axes of information, the provider, the disease and the population, we will not be able to take as comprehensive an effort towards improving that.

All that being said, I think MedPAC providing this kind of road map is very important given that our reports do get the kind of audience that they get. I think having the staff you have devoted to this, and as Mary said, having this be a pervasive theme in our work is something that is broadly appreciated and I'm glad we're doing it.

Could you briefly comment on the provider, the disease, and the population hypothesis?

MS. MILGATE: I was actually going to turn that back to a question to you. I guess I agree. I think those are probably the four levels of analysis that give you the broadest picture. And then, of course, within that you get different ways of looking at quality within each of those which gives you a fairly complex matrix.

What I was wondering if you were suggesting that even though our natural work or focus would be on the provider level, that we should broaden that or have some emphasis in the chapter that goes beyond that? Or are you suggesting that would be kind of a framework?

MR. MULLER: What I'm suggesting is that to ultimately understand the benefit of medical interventions, one has to understand it sort of at the provider level but also has to be able to break it down beyond that to understand the variety of diseases, the variety of conditions being treated, as well as obviously the populations being served.

MS. MILGATE: Certainly, in terms of designing and targeting appropriate interventions to improve quality, if you don't have all three of those you're really not quite sure where you're going.

MR. MULLER: But my point on standardization kind of cuts against that because I think one of the problems in the whole quality measurement efforts has been they are so varied, they are so different, they are so diffuse that people can't get a handle on it. And therefore, I think -- I mean, there's been a variety of efforts in recent years to kind of standardized it and those efforts haven't had as much success as the initiators might have hoped for.

So I think, in some ways, if we almost have a different measure for every last disease and every last provider, and then we don't have a good comprehensive way of talking about it.

One of the points I always make at my institution is we've had 50 years to develop financial reports and people who have a knowing eye know the four or five things to really look for in 50 pages.

When one looks at quality, there aren't four or five things one goes to really look for in any kind of -- whether it's in the

Medicare program or whether it's an institution or it's a set of doctors or it's in geography, or it's in a health plan. So I think in some ways that -- I'm not saying MedPAC by itself is going to resolve it, but I do think having a more standard way of talking about it is of critical importance.

DR. NEWHOUSE: I'd actually like to sharpen this point. I think we need to make a meta-point starting out that conceptually quality ought to relate to the patient or the beneficiary. That is how the patient's problem was treated, or in some cases prevented from happening in the first place. That's really, I think, the ultimate test of quality. And that has many implications.

One is that information across the various sites really needs to be combined to have any handle on how the person is being treated. And one link in the chain may be doing fine, but that doesn't mean that the patient is doing fine.

Second, that in the context of traditional Medicare really, conceptually is contrasted with M+C. There are several things that cut against this. One we talked about is the silo of reimbursement. Even if you give incentives to one link for quality, you may not get it elsewhere. An exception to the possibly is the lack of payment for coordinating across various providers or services.

The second is that, in fact, even the private instruments we have for quality, such as accreditation and certification, really are provider-based and don't really work very well at the problem of how is it from the point of view of the patient receiving services from potentially many providers in terms of how it ultimately all comes out.

It's very hard for me to overstate the importance of that point. It's there in the Chasm report but it tends to get lost because we're so used to thinking about quality in the provider context.

Then there was one sentence that I didn't understand, that you said because the data of the QIO come from medical record review it's hard to use them to compare care in different regions. Is that because they're taking different problems on?

MS. MILGATE: No, it's just because it takes so much effort to get the information out of the medical record that you don't have a sample that's large enough to do any level of aggregation other than state or national.

DR. NEWHOUSE: That's not really an inherent barrier. That's an issue of the amount of resources you're putting into the entire effort. And if quality is the issue that we all think it is, it surely could use the resources enough to compare across regions. I mean, look at Nancy-Ann and Steve Jencks have the state stuff and that certainly shows a fair amount of disparity.

MS. MILGATE: No, state and national they can do. They just can't do anything urban/rural or at a lower level of aggregation other than state.

DR. NEWHOUSE: But again, it goes --

MS. DePARLE: [off microphone] It's limited by the budget.

DR. NEWHOUSE: That was my point, that it's really a resource issue. It's not a technical issue.

MS. MILGATE: That's right, you could collect more medical records and get a better sample.

MS. RAPHAEL: My point was the point that Joe is making, which I want to embellish somewhat. I think this is terrific, but I think sometimes we get too wrapped up in all the measurement systems in the data. And I think we need to do a little more to think about what are the questions we're trying to answer here.

And I think we do want to try to get at the patient experience. And I think from the beneficiary's point of view, they would want to know how safe this system is, how much confidence they should have in the system. And I think their experience of the system, as Joe pointed out, from my point of view, is very different than the way the data is currently captured. And I recognize the barriers to try to reconfigure that. But I think we need to be mindful of it. And we said before that these sort of transitions, that when you put all of the parts together they don't necessarily move in tandem, is important issue.

Now you do say you're going to try to answer questions like is quality improving or declining. I don't know how you're going to get at that, but I think that is a legitimate question. And if you focus on an area, does it make any difference? Now that CMS has focused on nursing homes, a year or two later, do we see any impact whatsoever?

So from my point of view, I would like a little more time spent on thinking about the questions we want to answer in this chapter and how the data, even if we really do this well, is going to be applied and used.

MS. MILGATE: Can I just make a comment on the across setting point that both of you have made? I would definitely suggest that's something we should talk about in the report because clearly that came out in the discussion in the June chapter, as well. But one thing we might want to look at, in terms of a research agenda, is perhaps if there's an ability to link some of these databases by beneficiary. I don't know if that's what you were leading to do, just to look for one beneficiary, does it look a certain way or that kind of thing might be really interesting to look at. So that would be one thought.

Just another point on your under questions, I think that's the tension that everyone that's starting out to try to measure quality are faced with. Okay, do we define the questions and then try to create the data? Or do we look at where the data are and then make the questions?

So yes, I think that's a really good point and we'll see if we can pull back a little bit and say what are we really trying to answer?

MS. BURKE: Two points. One is to further state the point that's been made, which is navigating through the quality world is difficult for people who don't live in it. And if we could do nothing more than help people understand the context in what we're trying to measure and what the point of the exercise is, and bring all of these pieces together, I think it would be

enormously helpful.

One suggestion, and you did it a little bit in this document but I think it needs to be done more, again looking at who the audience for the materials will be. And that is literally a glossary. There is technospeak that people that do quality talk to each other that people who don't get lost in. Whether you're talking about the CAHPS study or whatever it is, having some glossary so people get some handle on all of the moving parts in this, I think would be very helpful.

And you do pick up some of that in the back when we're talking about the RAND indicators and we're talking about CAHPS and we're talking about QIO. But I think some clarity so people understand the pieces that we're looking at.

The other thing I was struck by is in your key points, as you're looking at what it is that you're going to look at, the first question which I think tries to get at some of what it is that people have been raising, which is what do we know about the gaps? What do we not know? What is it we do not yet know how to measure? What are we missing, I think would be enormously helpful.

But the reference to the types of people that may be getting worse care than others, I think some clarification of what type means. Does it mean racial disparities? Does it mean age? Does it mean location of service? I think again, clarity as you're looking through these things, assuming the audience may not be as knowledgeable as many others in terms of what the point of the exercise is and how far along we've actually come in terms of understanding these things.

DR. NELSON: Among these quality indicators, ACE-PRO is a little bit unique because we initiated it, as I understand. And my question is what status as it in its development? Has it been piloted? Where are we with that?

MS. MILGATE: They were developed and piloted, and we've use them several times for a variety of different purposes in the last few years. They were developed originally in 1995. And interestingly enough, we're planning on revising them in our coming year.

So we are working on a contract actually as we speak to try to revise and to make sure that they are up to date in terms of conditions, as well as indicators within the current conditions.

MR. SMITH: Karen, this is very good stuff and I thank you very much.

Mark, I found as I read the mailing materials that the infusion of the quality questions throughout the chapters was impressive. It's a big step forward and I appreciate that as well.

Ralph started with a couple of hypotheses that he suggested sort of ought to guide the way we look at the data. I'd offer another one. My guess is, following up on Sheila, is the patient characteristics, income, health status, residence, probably are going to matter more than delivery institution.

And I'd like to include, as we go through this work, as much of an attempt to match up, whether this is a SNF or a long-term care hospital may not matter as much as whether or not the

patient has supplemental insurance or not, or lives alone or not, or is poor, or lives in Idaho.

So if we could work on both sides of that grid, my guess is we'll learn a lot more.

MR. FEEZOR: Following up on Ralph and David's point about focusing on where that patient is coming from and what the starting point is very important. But with that in mind, I wonder if we looked at, Karen, the number of things that you're going to try to array in the first cut urban/rural, maybe region, and then race as well as trends over time. I would urge us, for a variety of reasons, to go ahead in that first cut to also try to take a look at academic/non-academic.

MR. HACKBARTH: Okay, thank you very much, Karen.